

State of Alaska
Epidemiology



Bulletin

Recommendations
and
Reports

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CDC's Updated Sexually Transmitted Diseases Treatment Guidelines, 2006

**Summary of Major Changes from
2002 STD Treatment Guidelines**

with

**Chart of 2006 STD Treatment Guidelines for
Adolescents and Adults**

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Condensed 2006 Treatment Guidelines by Donna Cecere, Section of Epidemiology, with contributions from John Palmer and Pat Taylor, Southcentral Foundation; and Susan Jones, HIV/STD Program; and drawing from materials developed by the Washington State Department of Health, STD Program; National Coalition of STD Directors; National Network of STD/HIV Prevention Training Centers; and Delaware Division of Public Health, STD Program.

CDC's Updated Sexually Transmitted Diseases Treatment Guidelines, 2006

Introduction

The Centers for Disease Control and Prevention (CDC) released *Sexually Transmitted Diseases Treatment Guidelines, 2006* on August 4, 2006 (MMWR 2006; 55[No. RR-11]) to update Treatment Guidelines published in 2002. The full 2006 Guidelines are available at <http://www.cdc.gov/std/treatment> or by calling the Section of Epidemiology, HIV/STD Program at 907-269-8000.

This *Recommendations and Reports* highlights areas in which the 2006 CDC Guidelines update the 2002 Guidelines, focusing on major changes (with related page numbers referenced in parentheses). This document also includes links to additional sources of information relevant to STD treatment, and a condensed, updated chart of STD treatment guidelines for adults and adolescents for the most common infections.

Highlights from CDC's *Sexually Transmitted Diseases Treatment Guidelines, 2006*

Updates Related to Chlamydia, Gonorrhea, and Syphilis

- Chlamydia trachomatis infections during pregnancy: Clinical experience and three published studies suggest that azithromycin is safe and effective for the treatment of chlamydial infections during pregnancy (page 40).
- Dual treatment for chlamydia in individuals with gonorrhea: Because of the high sensitivity of NAATs (nucleic acid amplification tests) for chlamydial infection, patients with a negative NAAT result for chlamydia at the time of treatment for gonorrhea do not need to be treated for chlamydia, as well. If chlamydia test results are not available or if a chlamydia test other than NAAT was negative for chlamydia, patients should still be treated for both gonorrhea and chlamydia.
- Gonorrhea and increasing prevalence of quinolone-resistant *Neisseria gonorrhoeae* (QRNG): The prevalence of QRNG has risen in the United States, and this trend is predicted to continue (page 43). QRNG is more common among in men having sex with men (MSM) than among heterosexual men (23.9% compared with 2.9%). CDC advises that quinolones not be used for the treatment of gonorrhea among MSM, in areas with increased QRNG prevalence in the United States, or for infections acquired while traveling abroad.

The Alaska Section of Epidemiology recommends providers not use quinolones to treat gonorrhea infections in Alaska populations due to the high rates of travel to/from regions with high QRNG prevalence (e.g., Hawaii, California, Asia and the Pacific Islands).

- **Syphilis:** *Neurosyphilis.* Recent data on HIV-infected persons with neurosyphilis suggest that cerebrospinal fluid (CSF) abnormalities might persist for extended periods in these persons, and close clinical follow-up is warranted (page 28).

Penicillin allergies.

Penicillin allergies in pregnant women: Pregnant patients who are allergic to penicillin should be desensitized and treated with penicillin (page 25).

Penicillin allergies in people with HIV infection: The use of any alternative therapies in HIV-infected persons has not been well-studied; therefore, the use of doxycycline, ceftriaxone, and azithromycin among such persons must be undertaken with caution (page 25). Close follow-up of persons receiving alternative therapies is essential.

Use of azithromycin as an alternative therapy to penicillin G: Several cases of azithromycin treatment failure have been reported, and *Treponema pallidum* resistance to azithromycin has been documented in several geographic areas. Close follow-up is essential for persons receiving alternative therapies to treat syphilis (page 25).

Screening for HIV. All patients who have syphilis should be tested for HIV.

Updates Related to Other Conditions

- **Cervicitis:** Because cervicitis might be a sign of upper genital tract infection (endometritis), women who seek medical treatment for a new episode of cervicitis should be assessed for signs of PID and should be tested for *C. trachomatis* and *N. gonorrhoeae* with the most sensitive and specific test available, NAAT. Women with cervicitis should also be evaluated for bacterial vaginosis (BV) and trichomoniasis (page 37). Because the sensitivity of microscopy to detect *Trichomonas vaginalis* is relatively low (approximately 50%), symptomatic women with cervicitis and negative microscopy for *T. vaginalis* should receive further testing (i.e., culture or antigen-based detection). (See page 52 for a description of commercially available FDA-cleared, point-of-care diagnostics for *T. vaginalis*.)
- **Hepatitis C Virus (HCV) Infection:** Increased information is presented from surveillance and studies. Overall findings continue to indicate that sexual transmission of HCV is possible but inefficient (page 76).
- **Nongonococcal Urethritis (NGU):** The etiology of the majority of cases of nonchlamydial NGU is unknown. *Ureaplasma urealyticum* and *Mycoplasma genitalium* have been implicated as etiologic agents of NGU in some studies; however, detection of these organisms is frequently difficult. Other potential causes of NGU include *T. vaginalis*, HSV, and adenovirus. Diagnostic and treatment procedures for these organisms are reserved for situations in which these infections are suspected (e.g., contact with trichomoniasis and genital lesions or severe dysuria and meatitis, which might suggest genital herpes) or when NGU is not responsive to therapy (page 35). Standardized diagnostic tests for *M. genitalium* are not commercially available. *M. genitalium* responds well to treatment with azithromycin (page 36).

Some cases of recurrent urethritis after doxycycline treatment might be caused by tetracycline-resistant *U. urealyticum* (page 36).

- Proctitis, Proctocolitis, and Enteritis: Acute proctitis of recent onset among persons who have recently practiced receptive anal intercourse is usually sexually acquired. Such patients should be examined by anoscopy and should be evaluated for infection with herpes simplex virus (HSV), *N. gonorrhoeae*, *C. trachomatis*, and *T. pallidum*. If painful perianal ulcers are present or mucosal ulcers are detected on anoscopy, in addition to HSV infection, lymphogranuloma venereum (LGV) proctitis and proctocolitis also should be considered and appropriate diagnostic testing for LGV conducted (page 78).
- Lymphogranuloma Venereum (LGV): LGV is caused by *C. trachomatis* serovars L1, L2, or L3. Rectal exposure in women or men having sex with men might result in LGV proctocolitis (including mucoid and/or hemorrhagic rectal discharge, anal pain, constipation, fever, and/or tenesmus). Diagnosis is based on clinical suspicion, epidemiologic information, and the exclusion of other etiologies and results of *C. trachomatis* testing, if available (page 21). Genital and lymph node specimens (i.e., lesion swab or bubo aspirate) may be tested for *C. trachomatis* by culture, direct immunofluorescence, or nucleic acid detection. Nucleic acid amplification tests (NAAT) for *C. trachomatis* are not FDA-cleared for testing rectal specimens. Additional procedures (e.g., genotyping) are required for differentiating LGV from non-LGV *C. trachomatis* but are not widely available. Additionally, *C. trachomatis* serovar-specific serologic tests are not widely available (page 22). Contact the Anchorage Public Health Laboratory at (907) 334-2100 for instructions on testing for LGV.

Sex partner follow-up. Persons who have had sexual contact with an LGV-infected patient within the 60 days before onset of the patient's symptoms should be examined, tested for urethral or cervical chlamydia infection, and treated with a standard chlamydia regimen. The optimum contact interval is unknown; some specialists use longer contact intervals (page 22).

- Trichomoniasis:
New antimicrobial recommendation for trichomoniasis: metronidazole 2 g orally in a single dose continues to be recommended for treating trichomoniasis, and tinidazole 2 g orally in a single dose is a newly recommended regimen (page 52).

Updates Related to STD Prevention Approaches

- **Prevention Counseling and Education**: Key techniques for effective prevention counseling and education (e.g., the use of open-ended questions, understandable language, and the normalization of language) are described under the Clinical Prevention Guidance (page 2).
- **STD/HIV Prevention Counseling**: Interactive counseling approaches directed at a patient's personal risk, the situations in which risk occurs, and the use of goal-setting strategies are effective in STD/HIV prevention (page 3). This section discusses client-centered counseling interventions (e.g., Project RESPECT) and motivational interviewing models (see related links, below).
- **Prevention Methods**: Under the sub-heading, Client-Initiated Interventions to Reduce Sexual Transmission of STD/HIV and Unintended Pregnancy, new content covers *Abstinence and Reduction of Number of Sex Partners*, *Preexposure Vaccination*, *Emergency Contraception (EC)*, and *Postexposure Prophylaxis (PEP) for HIV* (pages 3–5).
- **Partner Management**: This section now includes information on the use of expedited partner therapy (EPT) in communities in which 1) comprehensive partner notification services are unavailable, and 2) local laws allow for the prescribing or distribution of medications to individuals not seen by the provider (pages 5–6).

Updates Related to Sexual Assault and STD

- **Prophylaxis**: The following regimen is suggested as preventive therapy (page 82):
 - 1) postexposure hepatitis B vaccination, without HBIG at time of initial examination (if patient has not previously been vaccinated), with follow-up for the second and third doses;
 - 2) an empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas, and BV; and
 - 3) emergency contraception should be offered if the postassault could result in pregnancy in the survivor.
- **HIV prophylaxis**: Although a definitive statement of benefit cannot be made regarding (PEP) after sexual assault, the possibility of HIV exposure from the assault should be assessed at the time of the postassault examination. Guidance is provided for this assessment and on information about PEP to be discussed with the patient. Specialist consultation on PEP regimens is recommended if PEP is being considered. The sooner PEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission, if HIV exposure occurred (page 82).

Links for Additional Information Related to the 2006 Guidelines

- Alaska disease reporting requirements are available at:
<http://www.epi.alaska.gov/pubs/conditions/default.stm>.
- A video podcast entitled, STD Treatment Guidelines, 2006 can be found at:
<http://www.cdc.gov/podcasts/player/3130.htm>. CDC Drs. Kimberly Workowski and John Douglas are featured discussing regimens for suppressive antiviral therapy for (and role in decreasing transmission of) HSV-2; preexposure vaccination for HPV for prevention of cervical cancer; increasing STD rates among MSM with guidance on risk assessment for all male patients and routine STD laboratory screening for MSM; and HIV testing and hepatitis B vaccination as prevention strategies.
- A flow chart on LGV proctocolitis diagnosis is available at:
<http://www.cdc.gov/std/lgv/LGVflowchart5-22-2006.pdf>.
- Information on a range of effective behavioral interventions, including Project RESPECT, is available at: <http://effectiveinterventions.org>.
- Information on client-centered counseling training opportunities in Alaska is available by calling the HIV/STD Program at (907) 269-8000. For trainings nationwide see <http://www.stdhivpreventiontraining.org> for information on the National Network of STD/HIV Prevention/Training Centers with links to a center in each region.
- Western Region trainings in partner services and on Project RESPECT are conducted by the California STD Prevention Training Center. A schedule is available at:
<http://www.stdhivtraining.org/cfm/schedule.cfm>.

Condensed 2006 STD Treatment Guidelines: Adolescents and Adults

This table of treatment of STD reflects the [2006 CDC Guidelines for Treatment of Sexually Transmitted Diseases](#). It is not a comprehensive list of all diseases or recommendations in the Guideline, and does not address infection in children or neonates. The complete 2006 Guidelines are available from the CDC web site at <http://www.cdc.gov/std/treatment/default.htm>.

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVE TREATMENT	COMMENTS
BACTERIAL VAGINOSIS (BV)	<p>Metronidazole 500 mg orally 2x/day for 7 days OR Metronidazole gel (0.75%) one full applicator (5g) intravaginally daily for 5 days OR Clindamycin cream¹ (2%) one full applicator (5 g) intravaginally at bedtime for 7 days</p>	<p>Clindamycin 300 mg orally 2x/day for 7 days OR Clindamycin ovules¹ 100 g intravaginally once at bedtime for 3 days</p>	<p>Single dose metronidazole 2 g is no longer recommended as an alternative regimen for BV due to its low efficacy. Avoid alcohol for 24 hours following metronidazole.</p> <p>¹Clindamycin cream and ovules are oil-based and may weaken latex condoms and diaphragms for 5 days after use.</p>
Pregnant women	<p>Metronidazole 500 mg orally 2x/day for 7 days OR Metronidazole 250 mg orally 3x/day for 7 days OR Clindamycin 300 mg orally 2x/day for 7 days</p>		If used, intravaginal clindamycin cream should only be used during the first half of pregnancy.
CHLAMYDIAL INFECTION	<p>Azithromycin 1 g orally in a single dose OR Doxycycline 100 mg orally 2x/day for 7 days</p>	<p>Erythromycin base 500 mg orally 4x/day for 7 days OR Erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days OR Ofloxacin 300 mg orally 2x/day for 7 days OR Levofloxacin 500 mg orally once daily for 7 days</p>	<p>Providers should consider advising all women with chlamydial infection to be retested 3 months after treatment to rule out subsequent re-infection. Providers are also strongly encouraged to test all women treated for chlamydial infection when they next present for care within the following 3–12 months.</p>
Adults or adolescents ≥45 kg, with uncomplicated infection of the cervix, urethra, or rectum.			
Pregnant women	<p>Azithromycin 1 g orally in a single dose OR Amoxicillin 500 mg orally 3x/day for 7 days</p>	<p>Erythromycin base 500 mg orally 4x/day for 7 days OR Erythromycin base 250 mg orally 4x/day for 14 days OR Erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days OR Erythromycin ethylsuccinate 400 mg orally 4x/day for 14 days</p>	<p>Clinical experience and studies suggest that azithromycin is safe and effective for use during pregnancy. Erythromycin estolate is contraindicated during pregnancy because of drug-related hepatotoxicity. Quinolones and tetracyclines are contraindicated in pregnant and lactating women. Repeat testing, preferably by NAAT, 3 weeks after completion of medication regimen is recommended for pregnant women to ensure therapeutic cure.</p>
EPIDIDYMITIS	<p><i>For acute epididymitis most likely caused by gonococcal or chlamydial infection; empiric treatment recommended</i> Ceftriaxone 250 mg IM in a single dose ▶▶ PLUS ▶▶ Doxycycline 100 mg orally 2x/day for 10 days</p>	<p><i>For epididymitis most likely caused by enteric organisms, patients allergic to cephalosporins and/or tetracyclines, or patients >35 years of age (in whom sexual transmission is uncommon); empiric treatment is recommended</i> Ofloxacin 300 mg orally 2x/day for 10 days OR Levofloxacin 500 mg orally once daily for 10 days</p>	<p>If the diagnosis of epididymitis is questionable, a specialist should be consulted immediately because testicular viability may be compromised. Failure to improve within 72 hours of initiation of therapy requires reevaluation of both the diagnosis and the therapy.</p>
GENITAL HERPES SIMPLEX (HSV)	<p>Acyclovir 400 mg orally 3x/day for 7–10 days OR Acyclovir 200 mg orally 5x/day for 7–10 days OR Famciclovir 250 mg orally 3x/day for 7–10 days OR Valacyclovir 1 g orally 2x/day for 7–10 days</p>	<p>Treatment may be extended if healing is incomplete after 10 days of therapy.</p> <p>The safety of Acyclovir and Valacyclovir during pregnancy has not been established. For treatment during pregnancy see the CDC Treatment Guidelines.</p>	
First clinical episode of genital herpes			
Episodic recurrent infection	<p>Acyclovir 400 mg orally 3x/day for 5 days OR Acyclovir 800 mg orally 2x/day for 5 days OR Acyclovir 800 mg orally 3x/day for 2 days OR Famciclovir 125 mg orally 2x/day for 5 days OR Famciclovir 1000 mg orally 2x/day for 1 day OR Valacyclovir 500 mg orally 2x/day for 3 days OR Valacyclovir 1 g orally once a day for 5 days</p>	<p>Effective episodic treatment of recurrent herpes requires initiation of therapy within one day of lesion onset, or during the prodrome that precedes some episodes. The patient should self-initiate treatment when symptoms begin.</p>	
Daily suppressive therapy	<p>Acyclovir 400 mg orally 2x/day OR Famciclovir 250 mg orally 2x/day OR Valacyclovir 500 mg orally once a day OR Valacyclovir 1 g orally once a day</p>	<p>Suppressive therapy reduces frequency of genital herpes recurrences by 70%–80% in patients who have frequent recurrences (≥6 per year) and many patients report no symptomatic outbreaks. Periodically (e.g., annually) discuss need for continuation.</p> <p>Daily treatment with valacyclovir 500 mg decreases the rate of HSV-2 transmission in discordant, heterosexual couples.</p>	
GONOCOCCAL INFECTION	<p>Ceftriaxone² 125 mg IM in a single dose OR Cefixime³ 400 mg orally in a single dose ▶▶ PLUS ▶▶ <i>if chlamydial infection is not ruled out</i> Azithromycin 1 g orally in a single dose OR Doxycycline 100 mg orally 2x/day for 7 days</p> <p>²Ceftriaxone is recommended for treatment of pharyngeal infection with gonorrhea ³Cefixime is currently available only in an oral suspension</p>	<p>Spectinomycin⁴ 2 g IM in a single dose, OR single-dose cephalosporin OR single-dose quinolone</p> <p>⁴Spectinomycin is currently unavailable. Negotiations are underway to return this medication to the United States market.</p>	<p>Quinolones are no longer recommended treatment for gonorrhea infections in Alaska due to the close proximity to and high rate of travel to and from regions with high incidence of quinolone-resistant <i>N.gonorrhoeae</i> (QRNG) such as Hawaii, the United States West Coast, Asia and the Pacific Islands.</p>
Adults or adolescents ≥45 kg, with uncomplicated infection of the cervix, urethra or rectum.			
Pregnant women	<p>See 2006 CDC Treatment Guidelines: Pregnant women should <u>not</u> be treated with quinolones or tetracyclines. Treat gonorrhea with a recommended or alternate cephalosporin. For presumptive or diagnosed <i>C. trachomatis</i> infection during pregnancy, either azithromycin or amoxicillin is recommended for treatment (see “Chlamydial infection,” above). Repeat testing, preferably by NAAT, 3 weeks after completion of medication regimen is recommended for all pregnant women to ensure therapeutic cure.</p>		

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVE TREATMENT	COMMENTS
HUMAN PAPILLOMAVIRUS (HPV)	<i>Patient-applied:</i> Podofilox 0.5% solution or gel. Apply to visible warts 2x/day for 3 days, rest 4 days, may repeat up to 4 cycles maximum OR Imiquimod 5% cream. Apply once daily at bedtime (wash off after 6–10 hours) 3x/week, for a maximum of 16 weeks <i>Provider-administered:</i> Cryotherapy with liquid nitrogen or cryoprobe. Repeat every 1–2 weeks until resolved		For patient-applied treatments, patients must be able to identify and reach all warts requiring treatment. If possible, the health care provider should demonstrate proper application technique.
Genital warts	OR Podophyllin resin 10%–25%. Apply sparingly to warts only, allow to air dry, may be washed off in 1–4 hours. Repeat weekly, if necessary. OR Trichloroacetic acid or Bichloroacetic acid 80%–90%. Apply sparingly to warts only, allow to air dry. Repeat weekly, if necessary. OR Surgical removal <i>Alternative regimens: intralesional interferon or laser surgery.</i>		For pregnant patients or those with vaginal, cervical, urethral meatus or anal warts, see 2006 CDC Treatment Guidelines.
NONGONOCOCCAL URETHRITIS (NGU)	Azithromycin 1 g orally in a single dose OR Doxycycline 100 mg orally 2x/day for 7 days	Erythromycin base 500 mg orally 4x/day for 7 days OR Erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days OR Ofloxacin 300 mg orally 2x/day for 7 days OR Levofloxacin 500 mg orally once daily for 7 days	Patients who do not respond following completion of oral therapy should be re-evaluated. See 2006 CDC Guidelines for treatment of recurrent or persistent urethritis.
PELVIC INFLAMMATORY DISEASE (PID)	Oral Treatment <i>Regimen A</i> (if gonococcal PID is suspected, use Regimen B): Levofloxacin 500 mg orally once daily for 14 days OR Ofloxacin 400 mg orally twice daily for 14 days <i>with or without</i> Metronidazole 500 mg orally twice daily for 14 days <i>Regimen B:</i> Ceftriaxone 250 mg IM in a single dose OR Cefoxitin 2 g IM in a single dose <i>and</i> Probenecid 1 g orally concurrently in a single dose OR other parenteral third-generation cephalosporin (e.g., ceftizoxime or cefotaxime) ▶▶ PLUS ▶▶ Doxycycline 100 mg orally 2x/day for 14 days <i>with or without</i> Metronidazole 500 mg orally twice daily for 14 days	Parenteral Treatment <i>Regimen A:</i> Cefotetan 2 g IV every 12 hours OR Cefoxitin 2 g IV every 6 hours ▶▶ PLUS ▶▶ Doxycycline 100 mg orally or IV every 12 hours <i>Regimen B:</i> Clindamycin 900 mg IV every 8 hours ▶▶ PLUS ▶▶ Gentamicin loading dose IV or IM (2 mg/kg of body weight followed by a maintenance dose (1.5 mg/kg) every 8 hours. Single daily dosing may be substituted. Parenteral therapy may be discontinued 24 hours after a patient improves clinically, and oral therapy with Doxycycline (100 mg orally twice a day) or clindamycin 450 mg orally four times a day should continue to complete a total of 14 days of therapy.	<i>For pregnant women:</i> 1. Because of the high maternal and fetal morbidity and preterm delivery, pregnant women with suspected PID should be hospitalized and treated with parenteral antibiotics. 2. The decision to hospitalize a woman with PID depends on the clinical severity of symptoms, and expected non-compliance with oral treatment guidelines. 3. Doxycycline should not be administered during pregnancy or lactation. 4. Quinolones are contraindicated for pregnant or lactating women. 5. Patients with PID who do not respond to oral therapy within 72 hours should be re-examined and if there is no improvement, should be hospitalized for parenteral therapy and further evaluation.
PUBIC LICE (PEDICULOSIS PUBIS)	Permethrin (1%) cream rinse. Apply to affected areas, wash off after 10 minutes OR Pyrethrins with piperonyl butoxide. Apply to affected area, wash off after 10 minutes	Malathion (0.5%) lotion, wash off after 8–12 hours OR Invermectin 250 ug/kg repeated in 2 weeks	Lindane is <u>not</u> recommended as first-line therapy because of toxicity. It should only be used as an alternative because of intolerance or failure of first-line therapies. Patients with pediculosis pubis should be evaluated for other STD.
SCABIES	Permethrin cream (5%) Apply to all areas of body from neck down, wash off after 8–14 hours OR Invermectin 200 ug/kg orally, repeated in 2 weeks	Lindane (1%) Apply thinly 1 oz. of lotion, or 30 g of cream, to all areas of the body from the neck down. Wash off after 8 hours	Lindane should <u>not</u> be used immediately after a bath or shower, or by pregnant or lactating women, children < 2 years of age, or people with extensive dermatitis.
SYPHILIS	Benzathine penicillin G 2.4 million units IM in a single dose (<i>Long-acting bicillin</i>)	Data to support alternatives to penicillin are limited. The following may be effective in nonpregnant, penicillin-allergic, HIV-negative patients. Close follow-up is essential: Doxycycline 100 mg 2x/day for 14 days, OR Tetracycline 500 mg orally 4x/day for 14 days	Due to the complexities of diagnosing, staging, and determining best treatment protocols for syphilis infection; and for the detection and treatment of neurosyphilis; providers are urged to review the 2006 CDC Guidelines and to contact the Section of Epidemiology at 269-8000.
Early (infectious): primary, secondary, or latent <1 year			
Latent >1 year, latent of unknown duration, tertiary (cardiovascular, gummatous)	Benzathine penicillin G 7.2 million units IM total, administered as 3 doses of 2.4 million units IM each at 1 week intervals	For non-pregnant, HIV negative, penicillin allergic patients. Use only with close serological and clinical follow-up: Doxycycline 100 mg orally 2x/day for 28 days, OR Tetracycline 500 mg 4x/day for 28 days	Pregnant patients or patients with HIV who have penicillin allergy should be desensitized and treated with benzathine penicillin.
TRICHOMONIASIS	Metronidazole 2 g orally in a single dose [a pregnancy category B drug] OR Tinidazole 2 g orally in a single dose [a pregnancy category C drug]	Metronidazole 500 mg orally 2x/day for 7 days	Avoid alcohol for 24 hours following metronidazole and 72 hours following tinidazole.
VULVOVAGINAL CANDIDIASIS	<i>Intravaginal Agents</i> (These creams and suppositories are oil-based and may weaken latex condoms and diaphragms. Refer to condom product labeling for further information.) Butoconazole 2% cream, 5 g intravaginally for 3 days OR Butoconazole 2% cream, 5 g (sustained released) in a single application OR Clotrimazole 1% cream 5 g intravaginally for 7–14 days OR Clotrimazole 100 mg vaginal tablet for 7 days OR Clotrimazole 100 mg vaginal tablet, 2 tablets for 3 days OR Miconazole 2% cream 5 g intravaginally for 7 days OR Miconazole 100 mg vaginal suppository, 1 suppository for 7 days (continued in column to right) <i>Oral Agent</i> Fluconazole 150 mg oral tablet, one tablet in a single dose	OR Miconazole 200 mg vaginal suppository, 1 suppository for 3 days OR Miconazole 1,200 mg vaginal suppository, 1 suppository for 1 day OR Nystatin 100,000-unit vaginal tablet, 1 tablet for 14 days OR Tioconazole 6.5% ointment 5 g intravaginally, a single application OR Terconazole 0.4% cream 5 g intravaginally for 7 days OR Terconazole 0.8% cream 5 g intravaginally for 3 days OR Terconazole 80 mg vaginal suppository, 1 suppository for 3 days	Preparations for intravaginal administration of butoconazole, miconazole, and tioconazole are available over-the-counter (OTC). Self-medication with OTC preparations should be advised only for women who have been diagnosed previously with VVC and who have a recurrence of the same symptoms. Advise any woman whose symptoms persist after using an OTC preparation or who has a recurrence of symptoms within 2 months to seek evaluation with office-based testing.